
BUILDING A COMMUNITY-BASED HEALTH CARE SYSTEM

“I am committed to ensuring access to quality health care to every man, woman, and child in the District – no matter their ability to pay.”

Mayor Anthony Williams

Transforming Our Health Care Delivery System

In October 1999, the Mayor and the Council convened the Health Care System Development Commission to recommend strategies for transforming the District’s health care delivery system. In June 2000, the Council approved the Commission’s recommendations, which included increasing access to health services, especially primary care. The Commission’s work is the basis for the Mayor’s overall plan to restructure the health care delivery system and his FY2002 budget proposal.

The Status of the District Residents’ Health

Focusing the District’s resources on the core public health functions of outreach, education, health services delivery, and health status tracking has yielded some achievements. The District continues to lead much of the nation with its 31 percent decrease in the number of teen pregnancies. The city has improved early detection and treatment for breast and cervical cancer by increasing screening by 25 percent. The District has also increased by 1,800 the number of substance abuse treatment slots, eliminated waiting lists for most substance abuse services, and increased the number of community-based HIV prevention programs. The number of homes screened for environmental hazards has also doubled.

However, many health challenges remain. District residents still suffer disproportionately from preventable diseases. As of 1998, the five leading causes of death in the District are heart disease and strokes (291 and 58 deaths per 100,000 people compared 208 and 60 nationally); cancer (258 deaths per 100,000 people compared with 202 nationally); HIV/AIDS (47 deaths per 100,000 people compared with five nationally); and pneumonia and influenza (44 deaths per 100,000 people in the District). The occurrence of all of these conditions can be significantly decreased through education, screening, and early intervention. Equally important is the District’s high rates of substance abuse (16 deaths per 100,000 people compared with six nationally); infant mortality (12.5 deaths per 1,000 births compared with seven nationally); 92,000 District residents have uncontrolled high blood pressure and 24,000 have untreated diabetes. The District’s death rate is nearly two times

higher than the national average. African-American males living in the District have a life expectancy ten years less than the national average.

Building on the Health Commission's recommendations, transformation of the Public Benefit Corporation (PBC) has become the locomotive driving health system change. By the end of 2001, the transformation process for the District's crisis-ridden public health care delivery system will be fully implemented. This new system will provide District residents, regardless of their insurance status or ability to pay, with a community-based entry point, a "medical home," where they receive primary care and access to comprehensive services.

For more than 100 years DC General Hospital has been a focal point for hospital care for the District's uninsured residents. Due partially to the District's historic concentration of public dollars on hospital-based health services rather than on building an effective community-based primary care delivery system, key health indicators have remained far worse than the national average. As managed care grew more prevalent and enrollment in DC Healthy Families has grown, the demand for inpatient services at DC General, as well as the District's other hospitals, has declined.

Recognizing that the District health crisis is unlikely to improve unless major changes are made in both care delivery and reimbursement, after nine months of searching for an effective strategy, District leaders reached out to local and national health care delivery experts for help in transforming the health care safety net. A 'request-for-proposals' was distributed and review panel of health care experts selected the best proposal. The new system (Table 7-1 and Figure 7-1) – the DC-Washington Alliance for Community Health (the Alliance) – dramatically differs from the old system.

Strategic Priorities Guide the Transformation

In moving from a hospital-focused public health care delivery system to the new community-based, primary care-focused system the District will effect changes on every level of the health system. To advance this effort, the District is implementing a comprehensive set of strategic policy priorities:

- **Improving Community Health Providers and Access to Medications;**
- **Providing Health Insurance for Uninsured Adults and Immigrant Children; and**
- **Enhancing DOH Capacity Through Improved Health Information and Planning.**

Building on these systemic changes and the new comprehensive community-based primary care system, the city is focusing resources on attaining long-term health improvements through:

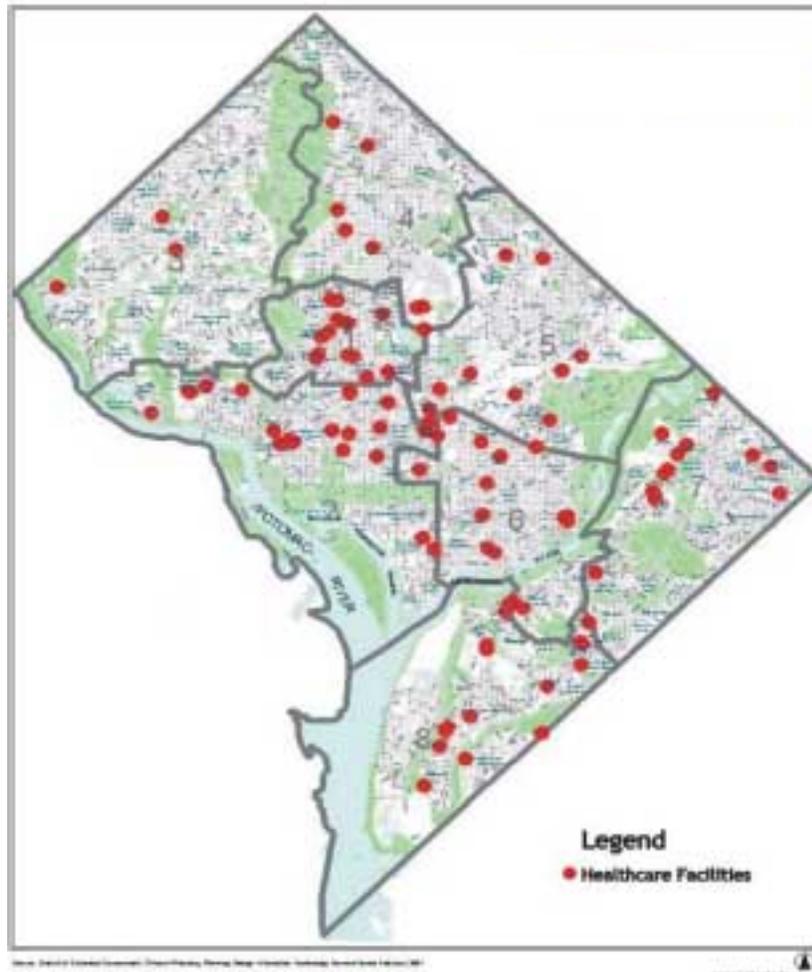
- **Improving Access to Substance Abuse and Drug-Related Violence Prevention Services;**
- **Building a Better Approach to HIV/AIDS;**

- **Instituting an Early Assessment and Support System for Mothers and Children;**
- **Rebuilding the District's Mental Health System from the Community Up; and**
- **Creating Healthy and Safe Home and School Environments for Children and Their Families.**

Table 7-1
Health System Reform Comparison

Quality Health System for District Residents	Current PBC System	New System <i>DC-Washington Alliance for Community Health</i>
Primary Care	<ul style="list-style-type: none"> ▪ Six existing community health centers ▪ Outpatient services at DC General Hospital 	<ul style="list-style-type: none"> ▪ Six existing community health centers ▪ Nearly 1,000 health care providers covering every neighborhood ▪ Additional primary and specialty care centers in Northeast and Southeast, outpatient services at DC General Hospital
Inpatient Care	<ul style="list-style-type: none"> ▪ DC General Hospital ▪ Poorly coordinated inpatient care at other hospitals 	<ul style="list-style-type: none"> ▪ Greater Southeast Community Hospital (GSCH) ▪ Access to the District's leading Medical facilities through Chartered Healthcare Plan ▪ All District hospitals maintain current levels of uncompensated care
Outpatient, Specialty & Diagnostic Care	<ul style="list-style-type: none"> ▪ DC General Hospital 	<ul style="list-style-type: none"> ▪ GSCH and DC General ▪ Access to the District's leading medical facilities through Chartered Healthcare Plan ▪ Top medical laboratories and specialty centers
Emergency, Trauma, & Urgent Care	<ul style="list-style-type: none"> ▪ DC General emergency and trauma ▪ Other District hospitals for emergency care 	<ul style="list-style-type: none"> ▪ 24-hour emergency/urgent care on DC General campus ▪ 24-hour emergency trauma care at GSCH ▪ Emergency care coordinated with other hospitals
Insurance	<ul style="list-style-type: none"> ▪ More than 65,000 District residents uninsured 	<ul style="list-style-type: none"> ▪ Provide HMO-type coverage for all uninsured residents who visit new network of neighborhood medical centers and urgent care facilities ▪ First phase of Medicaid coverage expansion to include 5,200 people

Figure 7-1
A New Beginning



Improving the health of District residents necessitates making primary health care services accessible to all District residents, regardless of where they live and what they earn. Through the new system the District will:

- Greatly expand government funded health care access points for insured and others in the current PBC system.
- Reduce hospital admissions for ambulatory sensitive diagnosis among the city's poorest and most vulnerable residents;
- Partner with community clinics to improve the quality and availability of health care for low-income residents; and
- Establish a pharmacy program that will aid uninsured residents in attaining the medicines they need to prevent illness and avoid hospitalization.

Improving Community Health Providers and Access to Medications

In the past, the District's community health centers have not received financial resources to improve their operations, increase their Medicaid revenues, and improve their competitiveness for managed care contracts. Instead, the District has paid heavily for institution-based health care. When people cannot afford to see a health provider, or cannot afford the medicines needed to treat acute and chronic conditions, they seek care in emergency rooms. To change this pattern the District must now build primary care capacity and expand access points in underserved neighborhoods.

Most existing public and nonprofit health centers are undercapitalized, have insufficient staffing levels and, in some cases, operate in inadequate facilities. The result is that uninsured patients seeking primary care face either long waiting periods for appointments or are referred to centers that may not be accessible or provide services in languages the residents understand. This situation is further exacerbated because the District has no comprehensive program that provides prescription drugs at no or low cost to the majority of the uninsured who are often unable to fill the prescription.

Establishing the DC Qualified Health Center Program

The PBC transformation will support the initial phase of a community network. The ongoing Alliance contract will provide one-third of the primary care visits needed by the District's uninsured population. The Mayor will convey to the District Council the legislation to create the DC Qualified Health Center program. The program will aid the nonprofit health centers that provide two-thirds of the District's primary care visits. The District will work with the Council to identify the funds needed to implement the DCQHC program. With these funds the District will:

- Establish common standards for the care delivered at the centers and achieve quality improvements;
- Provide resources for health center capacity-building including facility improvements, equipment purchases and MIS;
- Expand the number of providers, particularly in underserved neighborhoods through public private partnerships that include the renovation and leasing of District property; and
- Provide payments to community health centers for care delivered to uninsured District residents not covered by the Alliance contract.

As a result of these efforts, by the end of FY2005, the District will achieve health improvements including:

- Increase by 30 percent the number primary care visits;
- Reduce by 25 percent the number of emergency room visits;
- Increase to 75 percent the number of adults between the ages of 20 and 64 have had their blood cholesterol checked within the preceding five years;
- Increase to 50 percent the number of women aged 50 and older that have received a clinical breast examination and a mammogram within the preceding two years;
- Decrease to not more than one in six hundred the number of persons with asthma who are hospitalized for the care of asthma; and

- Improve 30 existing community-based non-profit community health centers and enable them to operate in more accessible health care delivery environments with effective information and billing systems.

Providing Prescription Drugs for the District's Uninsured Population

The Alliance contract covers the medications for one-third of the District's uninsured population. To provide prescription coverage for the remaining two thirds, the Mayor is requesting \$1 million in FY2002 and will work with the Council to identify additional funds. The District's proposed program parallels successful programs in other states and communities. Pennsylvania's Pharmaceutical Assistance Contract for the Elderly provides discounted medications to low-income seniors and is funded by state lottery proceeds. Maryland's Pharmacy Assistance Program (MPAP) requires participants to pay small co-payments for prescriptions. The MPAP covers medications for specific chronic conditions and includes anti-infective drugs, insulin syringes, and needles.

Through the District's proposed prescription assistance program, patients with conditions such as hypertension and diabetes will receive the medications their doctors prescribe and will avoid unnecessary emergency room visits and hospitalizations. The eligibility criteria will match those for the Alternative Financed Public Health System (System participants must earn under 200 percent of the federal poverty level, or under 300 percent with a chronic condition). The Department of Health will purchase pharmaceuticals at a discount through the Department of Defense, and distribute them through public and selected private pharmacies to uninsured patients who meet eligibility criteria. Bulk government purchasing and tight formulary control will keep costs low, and a utilization review program will ensure against fraud and abuse.

Providing Health Insurance for Uninsured Adults and Immigrant Children

Over the next three to five years, the District's goal is to extend health insurance coverage under the DC Healthy Families program to uninsured childless adults with incomes up to 100 percent of the federal poverty level (FPL). Through this expansion, an adult living without dependent children, with an income up to \$8,350, would receive publicly-funded, managed care health insurance.

With the institution of the DC Healthy Families program in 1998, the District's form of the federal Children Health Insurance Program, which covers children and their parents with family incomes up to 200 percent of the FPL, enrollment in Medicaid has significantly increased. Under DC Healthy Families and Medicaid, the District implemented aggressive outreach initiatives, including activities that enroll eligible families through the public school system, in supermarkets, pharmacies, and day care centers. After two and a half years, monthly Medicaid enrollment figures indicate that nearly 80 percent of all children who qualified are presently enrolled (63,535 children were enrolled as of July 2000). Additionally, nearly 8,000 more adults were enrolled in Medicaid as a result of this outreach. To help maintain this momentum as Medicaid coverage expansions are implemented, the District will expand its recently initiated workshops that train health care providers in eligibility determination.

Medicaid Coverage Expansion Phases I and II

The District is aggressively seeking a waiver and other means to expand Medicaid coverage, while still complying with federal laws and guidelines including maintaining Medicaid budget neutrality. Once approved, the District will expand this waiver through phased-in amendments that allow the District to increase the portion of uninsured residents covered by DC Healthy Families.

Phase I – Insuring Critical Populations

A total of \$5.2 million in local funds (along with a federal match of \$12.4 million) is included in the Mayor’s FY2002 budget for Medicaid expansion. To fully utilize these funds, the administration will submit for Council approval, planned changes to the District’s Medicaid State Plan that target resources where they will have the greatest impact on individuals’ lives:

- People with HIV generally do not qualify for Medicaid until they become disabled, so very few DC residents with early HIV infection currently have Medicaid coverage. Expanding Medicaid coverage to serve these individuals will allow the District to provide clinically recommended treatments to its residents diagnosed with HIV thereby preventing the disease progression to a full blown AIDS condition. This expansion is being implemented in FY2001 through a new waiver, that was approved in record time, to expand Medicaid eligibility to the working disabled. This cutting-edge strategy will allow the District to do what few other jurisdictions are doing, efficiently manage health care delivery for a portion of the HIV population and requires no new funding.
- The near-elderly age group (50 to 64) has worse health status than other adults, and they have a more difficult time obtaining affordable insurance because of the higher rates of chronic disease and disability. By extending coverage to this population, they could benefit from continuous coverage because they will become eligible for Medicare at age 65. The District has already submitted an 1115 waiver to the Health Care Financing Administration that would cover 1,216 uninsured childless adults ages 50 to 64 who have incomes below 50 percent of the FPL and will amend this waiver to include persons up to 100 percent of FPL with FY2002 funds.
- Younger adults age 19 through 27 account for the largest percentage of the uninsured population in comparison to all other age groups. Extending coverage to this age group would provide continuous coverage for adolescents aging out of Medicaid into young adulthood. In addition, health coverage for this population would ease the financial burden for low-wage workers who lack employer-sponsored insurance, especially those individuals transitioning back into workforce after leaving prison or welfare.

Phase II – Coverage Up to 100 percent of FPL for All

In the second phase, all adults with incomes up to 100 percent of the FPL will be covered.

Table 7-2
Phased-in Coverage Expansion for Childless Adults

Age	Percent of FPL	Population	Total Cost (includes federal match)	Expansion Phase
50-64	0-50	1,216	\$6.1 million	Phase I (pilot waiver)
19-27	0-50	3,200	\$7.5 million	Phase I

50-64	51-100	800	\$4.0 million	Phase I
19-27	51-100	2,300	\$5.4 million	Phase II
28-49	0-100	8,037	\$15.6 million	Phase II

Expanding Coverage for Immigrant Children

At the same time the District is expanding coverage to childless adults, it is also expanding District-funded health insurance coverage for foreign-born children who are excluded from the federal Medicaid program. This program is funded solely with local funds. In 2001, an amendment will be submitted to the legislation creating the Immigrant Children’s Insurance Program to allow the number of children covered to increase. The Mayor has included \$2.4 million in the FY2002 budget for this program.

Enhancing DOH Capacity Through Improved Health Information and Planning

The core functions and essential services of public health departments were outlined by the Institute of Medicine in 1988. This report delineated the key principles that guide the activities of health departments across the nation. Central among these, the three core functions of – assessment, policy development, and assurance of access to quality health care – drive public health department data collection and health system management activities.

Technology Supports Focus on Primary Care

Additional trends are forcing the health care industry and public health departments to reexamine their information tracking and assessment activities. These forces of change include a shift from disease treatment to prevention. Information systems that focus more on population and the determinants of health will support the increased integration of data and information. The District’s evolving health information system will allow the city to more effectively track, project and analyze disease trends and service utilization.

Underpinning the effective undertaking of the core functions of health departments and the health care industry in general is an effective information technology infrastructure. Since 1997, Department of Health (DOH) has been establishing such a system. In 1998, funding provided by the District’s Control Board provided the seed resources for a baseline infrastructure, specifically, hardware, software, and core training. Since then, the Department has developed an Information Technology Strategic Plan to guide activities in continued enhancement of its IT infrastructure, and established a ‘chargeback’ system to provide baseline resources required to maintain the IT infrastructure enhancements. Recently the Department prepared a document outlining a preliminary strategy for integrating information systems, focusing initially on the enhancement of internal information systems.

Partnerships Help Create an Integrated Health Data System

The Center for Disease Control and the Health Resources Services Administration have integrated their efforts to provide technical assistance for developing investment plans that can be funded from federal block grants. The Health Care Financing Administration is the principal funding source for Medicaid information systems. The District is utilizing these resources to build its integrated data system.

The District is building alliances and partnerships with community providers, universities, neighborhood groups, philanthropies, federal agencies, and state agencies in neighboring jurisdictions that will aid its integrated information system to serve multiple users and purposes.

Building a Better Infrastructure

The Mayor is requesting \$11.6 million in capital funds to purchase and adapt software and some additional equipment needed to build a comprehensive data tracking and planning system that links District agencies and health care providers.

By Spring 2001, the District will develop strategies for the full spectrum of available information and communication technologies that lead to planning and service improvements, including legacy systems, server-based platforms, data warehouses, datamarts, inter- and intranet, as well as, environmental health, GIS (geographic information system) and data mining technologies. By Fall 2001, the District will adopt a user-based approach to enhancing information technology. Gaining user participation in establishing effective information system and choosing data elements that are useful to providers as well as DOH are critical steps in developing a system that produces useful information. Information technology enhancement efforts will lead to the provision of standardized, accurate and holistic information that meets the health care information needs of the District. Thus DOH will establish uniform data elements and collect common data sets from providers located throughout the District.

Improvements from A to Z – Health Systems and Services

Improving the District's health indicators requires more than simply transforming our health care delivery system. To fully turn around our abysmal health indicators, we must 'marry' system reforms to improvements in the targeted public health services the District also provides its residents. These services provide the health promotion complement to the improved primary care, with coordinated secondary and tertiary care, delivered by our transformed system.

Improving Access to Substance Abuse and Drug-Related Violence Prevention Services

The challenges faced by the District are common to other urban cities. The District spends \$1.2 billion on services related to untreated substance abuse every year, considerably more than is spent on public education in the District.

The District's own successes in increasing the number of treatment opportunities, together with the experiences of other big cities like Los Angeles demonstrate that isolated, short-term approaches do not lead to pervasive change. Services must be designed to meet the needs of specific population groups and must be integrated within the community and across public and private programs. Nearly \$36 million in the Mayor's FY2002 budget is allocated for substance abuse programs. Of this amount, \$23 million is appropriated local funding.

Implementing a Comprehensive Strategy

During FY2001, the District will implement a comprehensive strategy that will expand the number of treatment slots and increase utilization through public/private partnerships that enhance the cultural diversity of the services provided, increase treatment utilization and outreach (e.g., employing mobilized education efforts), and expand education services for children in grades K-12. Within five years, the District will reduce the number of drug-addicted District residents by 25,000, increase treatment utilization, and reduce the annual cost of substance abuse-related services by \$300 million (public and private dollars). To meet these goals, the District is developing initiatives that fall largely into three overlapping categories:

- **Youth Services and Prevention Programs:** Interventions being used in the District have proven successful in other cities in decreasing hard drug use, including crack cocaine, and in lowering drug-related violence. Although alcohol and marijuana use is on the rise, programs designed and carried out by children and teenagers to educate peers are being developed and implemented. Models such as the SMART Moves National Prevention Program have had a great deal of success in urban settings such as Atlanta, Georgia in increasing adolescent self-image, resisting media pressures and promoting self-assertiveness. Similar programs designed to foster social skill building and curriculum development are being developed in the District. Included in the DC Youth Grand Jury report recommendations were that drug free clubs be created in public schools and teenagers be trained and certified as drug prevention counselors. The Jury report also cited the need for a teen hotline to address drugs and drug related problems.
- **Treatment:** Treatment available in the District will increase by 50 percent over the next five years to meet the ‘whole needs’ of individuals and their families. Treatment will particularly emphasize expanded inpatient care for women in the District that allows their children to stay with them; inpatient treatment for adolescents; integration of substance abuse treatment with mental health support and treatment, and access to social services, housing, job training, and other services. Plans are being developed to open up a multi-service treatment facility for juveniles in the District.
- **Community Education:** Under its comprehensive strategy, the District will expand the use of lay educators and community organizations for specified substance abuse services, including many in the languages spoken by the District’s immigrant populations. Community organizations with successful health promotion efforts, primary care clinics, and male health initiatives will be the focus of these grants.

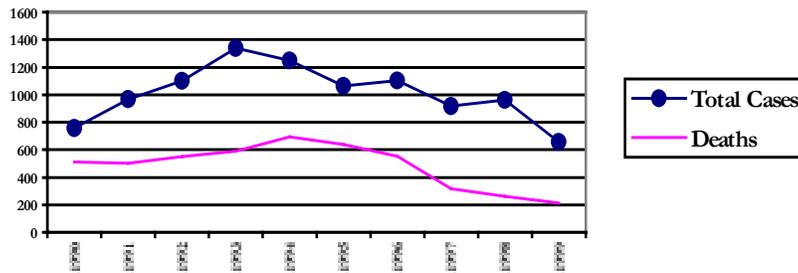
The District will also build a planning and assessment database, implement improved quality standards and monitoring of all treatment resources by assuming a ‘Single State Agency’ function (i.e. certifying programs), and establish data collection/evaluation mechanisms to measure achievement of the plan. Close cooperation with the District’s criminal justice and law enforcement agencies is imperative for the success of these efforts.

Building a Better Approach to HIV/AIDS

The District is committed to improving access to care and enhancing the quality of life of all its residents with HIV/AIDS. Through integrated services that will ensure early access to needed life saving interventions for 2001 and beyond, the District will focus on meeting the needs of those recently diagnosed with HIV and long-term survivors.

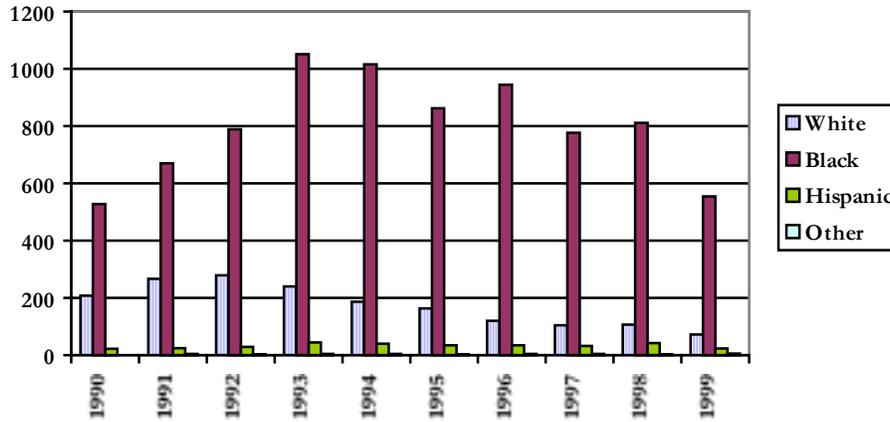
The good news is that the number of persons newly diagnosed with AIDS has been declining, as well as the number of deaths attributed to HIV/AIDS (Figure 7-2). The bad news is that the number of individuals with AIDS remains disproportionately higher in the District than in most other cities in the United States. In 1999, the AIDS case rate for the District was 161.5 per 100,000 people population compared to the 16.7 per 100,000 people for the United States as a whole. Major changes in national AIDS trends have taken place due to changes in the patterns of HIV transmission.

Figure 7-2
District of Columbia AIDS Cases By Year of Diagnosis and Year of Death 1990-1999



Data on new AIDS cases show a continued shift within the total number of people with AIDS to a larger proportion being comprised of persons of color, women, and injection drug users. Among males, diagnosed AIDS cases peaked in 1993 – the year that CDC expanded the definition of AIDS. Among females the peak was not reached until 1998. Additionally, AIDS transmission through heterosexual contact also continues to increase. At the end of 1999, of the number of AIDS cases, Black or African-Americans represented 75% of the cases, Whites represented 21% of the cases and Hispanics 3% of the cases. During 1999, more African-Americans were diagnosed with AIDS than in 1990 (Figure 7-3).

Figure 7-3
 District of Columbia AIDS Cases by Year of Diagnosis and Race/Ethnicity
 1990-1999



At the end of the 1980s, the numbers of reported AIDS infections that resulted from men having sex with other men (MSM) were almost equally divided between White and African Americans. Over the past 10 years, the proportion of African-Americans having contracted AIDS through men having sex with other men has grown to over 70% of the MSM reported cases (Figure 7-4). AIDS cases diagnosed among females whom were exposed to HIV through heterosexual contact is surpassing injection drug use (IDU) as the main mode of exposure among adult and adolescent females (Figure 7-5).

Figure 7-4
 Male District of Columbia AIDS Cases By Year of Diagnosis and Mode of Exposure
 1990-1999

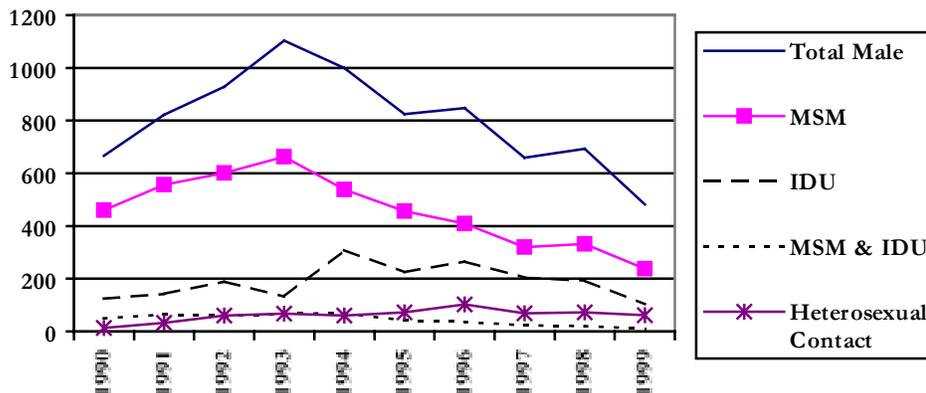
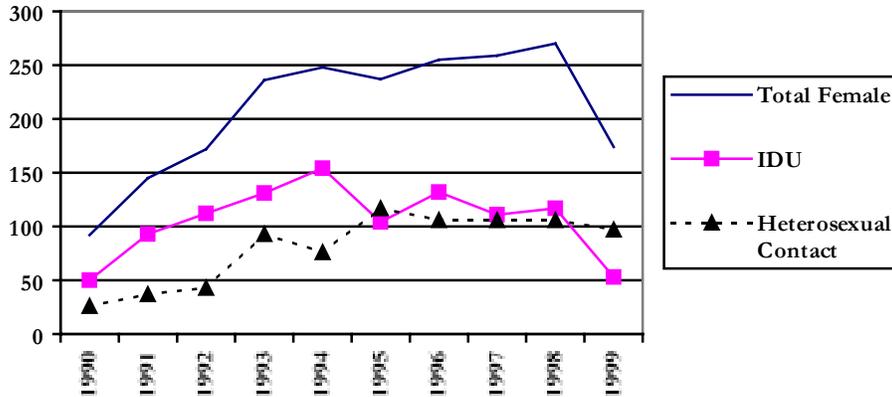


Figure 7-5
 Female District of Columbia AIDS Cases By Year of Diagnosis and Mode of Exposure 1990-1999



During 2001, the HIV Surveillance Implementation Advisory Group was formed to finalize the District’s unique identifier HIV tracking system which uses a numeric code to identify reported HIV infections. The District’s new system will be fully implemented by early FY2002. The unique identifier system will provide the District with the capability to identify and plan for trends in HIV infection in the District and to better design HIV prevention efforts.

The District’s FY2002 budget for HIV/AIDS programs is almost \$57 million of which nearly \$9 million is local funding. In FY2002 these efforts will support programs that reflect better data and strategies that reflect trends in increasing HIV and AIDS cases among women and populations of color.

Integrating Services

In keeping with CDC’s Draft Strategic Plan through 2005 and Ryan White CARE Act Reauthorization of 2000, the District will strengthen the linkages between prevention and care services. This initiative will coordinate and link HIV post-test services, prevention case management, primary and secondary prevention, and access to services for the affected populations.

DOH outreach efforts will focus on getting services to individuals who have recently contracted HIV. These individuals will greatly benefit from the receipt of early medical interventions and life-saving anti-retroviral medications. The District’s new HIV Medicaid waiver will ensure that persons in the early stages of the disease will be able to access a full spectrum of health services. Enhanced outreach programs will also intensify efforts to identify HIV clients who are not in treatment. Using the HIV counseling and testing sites in eight neighborhoods and the DC jail, the District intends to augment existing programs for emotional support, pre- and post-test information, and referral to services and interventions for the newly diagnosed. In addition, for these individuals, the amount of time given to apply for services will be shortened, facilitating immediate access to services.

Services to meet the housing needs of persons with HIV/AIDS will also be improved. The DOH Housing Division is centralizing and integrating its process using the Gatekeepers Initiative that will coordinate and case manage access to District-funded housing for families with HIV/AIDS.

Improving Services Through Public/Private Partnerships

The District is also developing new opportunities to partner with community and faith-based organizations and other community venues to provide counseling and testing services to HIV infected individuals and those at high risk.. The District's HIV service providers will receive a "Self Evaluation Tool Kit" (and its electronic version) to evaluate their HIV/AIDS prevention efforts and help enhance the services delivered.

Providing Necessary Medications

The AIDS Drugs Assistance Program (ADAP) provides free medications to qualified persons with HIV/AIDS. In FY2002, several strategies will be undertaken to increase the capacity of this program to get life-improving and extending medications to District residents who need them including:

- Media campaigns, training for providers and case managers;
- Computerized expedited processing of eligible clients;
- Intensive treatment education, testing and assessments to ensure that patients fully benefit from treatment regimen; and
- Updated formulary that includes new drugs.

Through these strategies, ADAP's goal is to increase by ten percent (above the 800 clients served during FY2001) the number of HIV/AIDS clients who access and utilize life saving medications in FY2002.

Instituting an Early Assessment and Support System for Mothers and Children

The infant mortality rate in the District has declined (from 14.4 per 1,000 births in 1996 to 12.5 in 1998). The city remains committed to ensuring that this downward trend continues and that infants receive the full range of medical and social services required to develop to full potential. To accomplish this goal, a broad spectrum of federally-funded programs has been integrated to build a comprehensive home visiting strategy. Currently, in addition to DC Healthy Families coverage, a number of District programs work together to ensure that pregnant women receive case management services and prenatal care, and are linked to ongoing medical care for themselves and their babies (Healthy Start in Wards 5 through 8 and the HEALTHLINE case management services in Wards 1 through 4). In addition, several community groups offer similar services such as the Healthy Babies project; Mary's Center for Maternal and Child Health (which received its own federal Healthy Start grant in FY2001), and Healthy Families DC.

Across the country, home visiting programs result in healthier mothers and babies. A recent evaluation of the District's federally-funded Healthy Start project, which emphasizes early home visiting services, showed a significant reduction in the proportion of low birth weight infants among enrolled mothers. Additionally, a number of program evaluations have confirmed that nurse home visiting reduces abuse and neglect of children.

The District's integrated home visiting efforts combine the Healthy Families America's (HFA) Intensive Home Visitation Program methodology with the Healthy Start program model. The HFA methodology is currently being implemented in over 40 states. Home visiting by nurse case managers provides an opportunity for parental education in the areas of parenting and safety, an assessment of social service needs such as referrals to WIC (Women's, Infant's and Children's program) or Medicaid, and assistance with linkages to primary care providers for follow up case management.

Implementing New Home Visiting Initiatives

Nationwide, home visiting programs have not yet become a fully integrated part of each state's child welfare system. Based on the District's experience with home visiting services, however, the Mayor is committed to this strategy as a key component for improving infant and maternal health. In FY2002, the District is utilizing \$1,223,000 from its federal Title V grant to support its home visiting initiatives and is applying for a total of \$2,960,000 through three additional federal grant programs.

The Newborn Home Visiting Initiative began operations in the first quarter of FY2001, enables new mothers who may not have enrolled in support services during pregnancy to receive a nurse home visit within 48 hours of their discharge from the hospital. Women and infants living in the sections of the city that have the highest rates of neonatal mortality will receive first priority for these services. This mayoral initiative will raise community awareness about the crucial role that home visiting can play in assuring maternal and infant health.

Every new mother discharged from District birthing centers receives a *Welcome Baby Package* including an invitation to schedule a nurse home visit, receive immediate case management services, and information on the Maternal and Family Health Administration's HEALTHLINE and community-based providers. Mothers who request home visits receive initial health assessments by a licensed community health nurse who also assists them in attaining a primary care physician and other family support services. In FY2002, \$723,000 is budgeted from the District's federally-funded Title V grant to cover 6,000 packages and 3,750 initial newborn home visits.

A New Case Management and Care Coordination initiative will begin in Spring 2001 to provide targeted outreach and home visits to high-risk families. The home-based care will begin during the prenatal period and will continue through the child's early preschool years. The focus of the District's new initiative is to develop a community-based network of outreach services for mothers and infants that will reduce infant morbidity and mortality. The initiative provides health and psycho-social support services as well as prevention of child abuse and neglect. In FY2002, \$500,000 is budgeted from the federally-funded Title V grant to provide case management to 275 – 300 high-risk families.

In addition to these two initiatives, the Mayor's goal to implement a more comprehensive home visiting strategy for the District that includes Medicaid managed care vendors who also provide home visiting services to families at higher risk.

Rebuilding the District's Mental Health System from the Community Up

To better meet the mental health needs of our residents, the District is implementing a new mental health delivery system. The system will be community-based and consumer- driven,

meeting the mandates of the *Dixon* lawsuit. This new system will be more integrated comprehensive, cost-effective, consumer- and family-driven, and will move the District's mental health system away from its historical role as a service provider and into the role of a mental health authority that oversees an integrated system of community care.

The system will be largely organized around nine new services and new provider requirements for continuity of care and access to services. The new services will be financed by better utilizing local funds and by adding the Medicaid Rehabilitation Option (MRO) to the Medicaid State Plan. This option allows the District to define and reimburse Medicaid-covered benefits that can be delivered in a range of community settings including a person's home and on the street. Almost all states have selected this option because it allows the state to develop services tailored to meet the needs of children with serious emotional problems and adults with long-term and disabling mental illnesses. In the last decade, MROs have been the primary source of new funding for community mental health services across the country. Community-based interventions are particularly effective in reducing out-of-state placements and long-term institutional placements for both adults and children. Most states report dramatic decreases, up to 80 percent in the number of placements and lengths of stay following implementation of these services.

Currently less than two percent of the District's residents receive services provided by or contracted by the Commission on Mental Health. This number should be increased to five percent based on community need. The goal is based upon findings from the 1999 DC Mental Health Needs and Services Estimation Project which projected that 7.5 percent of the District's youths and 5.8 percent of adults are living with severe mental health conditions. Additionally, the Mayor's new plan for mental health services places less reliance on institutions and increases the percentage of mental health dollars spent on community-based care from 30 percent of the FY2001 budget to 60 percent overtime.

Implementing the New Department of Mental Health Services

In Spring 2001, management of the mental health delivery system is due to be returned to the District.

The key components of the new system that will replace the receivership will be:

- Establishment of a Department of Mental Health;
- Implementation of the Medicaid Rehabilitation Option and operation of new programs that allow service delivery in natural settings and decrease the reliance on expensive institutional care;
- Creation and certification of a publicly operated Core Service Agency and contracting with other organizations that meet certification requirements as Core Service Agencies. Core Service Agencies will become "clinical homes" for all consumers of the system ensuring access and continuity of care for current consumers of mental health services;
- Implementation of a 24 hour/7 day a week Information and Referral Hotline to help consumers access services; and
- Expansion of a mobile outreach capacity to enhance the District's current psychiatric crisis response program.

In FY2002, the new Department of Mental Health is projected to receive \$66.9 million in federal dollars. The \$142.3 million amount in local funds is in the

Commission/Department's FY2002 budget. The legislation needed to enact the new department, the MRO and close the receivership was submitted to Council in spring 2001.

Creating Healthy and Safe Home and School Environments for Children and Their Families

While the challenges facing the District in improving home and schools are significant, Mayor Williams believes that all District children should grow up and learn in healthy and hazard-free home and school environments. The home and school hazards targeted through DOH's increasingly comprehensive environmental health strategy that includes: lead, rodents, asbestos, asthma triggers, harmful pesticides, homes protected from fire, and unhealthy air quality. Some improvements, including those in school food safety, have been achieved but much more remains to be done.

Elevated blood lead levels caused by lead dust impairs normal brain development in children. Rodent and roach infestations destroy property and convey disease. Child-onset asthma rates in the District of Columbia are now at least double the national average and are increasing. Uncontested research has established that asthma is an allergic disease and that its prime environmental triggers in children are exposure to cockroaches, molds, mites, and animal danders. The environmental health risks to children in schools should also include potential exposure to hazardous or toxic chemicals either from school laboratories pesticide residues or from school renovation activities, unsafe materials (e.g., exposed hypodermic needles) in school playgrounds, unsafe recreational equipment, and microbial agents amplified in school heating and air conditioning systems (e.g., *p. Legionella bacteria*).

- Household and school assessments use of cross-trained staff to carry out multiple functions during each assessment (e.g., lead-based paint, fire safety devices, evidence of rodent infestation, indoor environmental contaminants and allergens and infiltration of nearby external airborne contaminants);
- Education and outreach information to parents/guardians and educational officials, property owners and managers coupled with practical "healthy homes" outreach demonstrations;
- Mobile Health Units expansion of services offered via the District's mobile health vans. (e.g., auditory, blood and other medical screening services, well baby checks); and
- Collaborative relationships integration of work of existing community partnerships and federal agencies.

The District has a multi-part strategy for creating environmentally healthy homes and schools for children.

Promoting Comprehensive Home and School Assessments and Improvements

In FY2002, \$4.3 million for environmental health is included in the Mayor's budget, primarily for home health. Nearly \$3.5 million is appropriated local dollars. Over the next five years DOH's goal is to double the number of home health and safety services it provides annually, by raising an additional \$1 million in grant funds each year. In 2001, the Department of Health will submit an Indoor Air Quality bill that complements the District's existing ambient air quality law. This bill will provide inspectors the "right-of-entry" to multifamily housing, which is necessary for the effective assessment of environmental

hazards. Also in FY2002, the Mayor is committing \$150,000 from the Department of Health budget proposal to begin a series of environmental assessments of public schools and to work with the school system on corrections. The DOH will also work with DCPS, federal agencies, and private resources to obtain additional funds to meet the estimated need. While some repairs will result in maintenance cost savings that can be used to carry-out repairs, additional capital that is not currently included in the FY2002 proposed budget will be also be needed to correct the majority of hazards identified by the school assessments.

The District is working to cross-train inspectors, investigators, environmental engineers, and health educators. DOH conducts hundreds of environmental health assessments annually and believes it can increase this rate to several thousand per year by cross-training environmental engineers and other government staff to assess for multiple environmental hazards. There are approximately 81,000 school-aged children in the District, many are exposed to lead-containing dusts and more than 5,000 of which are estimated to be moderately to severely asthmatic.

Conclusion

Driven by the Health Care Commission's recommendations and the PBC transformation, the District's. In the short-term, the District's new community-based system of health care is targeting specific improvements in some of the city's worst health statistics, particularly those disproportionately affecting the District's, including:

- Decreasing deaths due to AIDS from 47 (100,000 population) in 1998 to 25 in 2003;
- Decreasing deaths due to Heart Disease from 291.1 (per 100,000 people) in 1998 to 189.15 in 2003; and
- Decreasing deaths due to Diabetes from 37.3 (per 100,000 people) in 1998 to 22.3 in 2003.

Over the longer term, the District's goals for Healthy People 2010 are to:

- Increase to 80 percent, from 66.7 percent in 1997, the proportion of pregnant women that begin prenatal care in their first trimester;
- Reduce infant mortality rate from 13.1 (per 1,000 live births in 1997) to eight;
- Decrease to less than five percent the number of eligible children and parents that are not enrolled in DC Healthy Families;
- Decrease from 29 percent to 15 percent the number of young people (ages 9-12) who report using illegal drugs;
- Reduce the proportion of children that register high blood lead levels from three percent currently to no more than one percent;
- Reduce the number of adult smokers from 18.8 percent to no more than 14 percent; reduce the young who are current smokers to 16 percent (currently, 24 percent of young men and 21.3 percent of young women); and
- Reduce by 40 percent the number of ER visits for diabetic complications.

These goals will be achieved through the systemic changes of building a true community-based and fully integrated primary care delivery system, expanding Medicaid coverage, enhancing DOH capacity and transforming our public health delivery system. These

systemic changes will work hand-in-hand with more targeted and better integrated health promotion efforts that will: increase substance abuse treatment services; provide earlier and more comprehensive care for persons with HIV; deliver home visits that serve a wider spectrum of mothers and children; implement comprehensive, integrated, and truly community-based mental health services; and ensure that every child living in the District lives in a home free of health hazards.